

Facility Name & ID Number Swann Special Care Center# 0035485 Report Period Beginning: 7/1/03 Ending: 6/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	<u>112</u>	Skilled Pediatric (SNF/PED)	<u>112</u>	<u>40,992</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>112</u>	TOTALS	<u>112</u>	<u>40,992</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	<u>39,487</u>	<u>732</u>	<u>0</u>	<u>40,219</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>39,487</u>	<u>732</u>		<u>40,219</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 98.11%

D. How many bed-hold days during this year were paid by Public Aid?

317 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 8/15/89

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 8/15/89NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified 0

and days of care provided

N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/04 Fiscal Year: 6/30/04

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number

Swann Special Care Center

0035485

Report Period Beginning:

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V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	209,332	15,895	12,569	237,796		237,796	(84,892)	152,904		1
2	Food Purchase		243,454		243,454		243,454		243,454		2
3	Housekeeping		26,447	112,951	139,398		139,398		139,398		3
4	Laundry	38,018	18,025	88,241	144,284		144,284		144,284		4
5	Heat and Other Utilities			79,539	79,539		79,539		79,539		5
6	Maintenance	49,852	16,022	46,114	111,988	85	112,073		112,073		6
7	Other (specify):*										7
8	TOTAL General Services	297,202	319,843	339,414	956,459	85	956,544	(84,892)	871,652		8
	B. Health Care and Programs										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	2,329,633	181,410	272,973	2,784,016	56	2,784,072		2,784,072		10
10a	Therapy	26,676	2,897	117,291	146,864		146,864		146,864		10a
11	Activities	214,502	2,126	400	217,028		217,028		217,028		11
12	Social Services	2,092	3,215	2,363	7,670		7,670		7,670		12
13	Nurse Aide Training										13
14	Program Transportation	16,686	7,993	1,524	26,203		26,203		26,203		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,589,589	197,641	430,551	3,217,781	56	3,217,837		3,217,837		16
	C. General Administration										
17	Administrative	59,815		188,953	248,768	(187,657)	61,111	(1,296)	59,815		17
18	Directors Fees					10,380	10,380		10,380		18
19	Professional Services			541,110	541,110	58,252	599,362		599,362		19
20	Dues, Fees, Subscriptions & Promotions			27,407	27,407	(154)	27,253	(3,903)	23,350		20
21	Clerical & General Office Expenses	119,656	31,377	31,236	182,269	46,445	228,714	(27,851)	200,863		21
22	Employee Benefits & Payroll Taxes			732,527	732,527	6,561	739,088	(4,824)	734,264		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,127	13,127	2,441	15,568	(2,213)	13,355		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			59,509	59,509		59,509		59,509		26
27	Other (specify):* Bad Debt			20,200	20,200		20,200	(20,200)			27
28	TOTAL General Administration	179,471	31,377	1,614,069	1,824,917	(63,732)	1,761,185	(60,287)	1,700,898		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,066,262	548,861	2,384,034	5,999,157	(63,591)	5,935,566	(145,179)	5,790,387		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			184,476	184,476	30	184,506		184,506			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			418,694	418,694	68,403	487,097	(27,731)	459,366			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,496	21,496	(4,842)	16,654		16,654			35
36	Other (specify):* Amortization			38,383	38,383		38,383	(27,835)	10,548			36
37	TOTAL Ownership			663,049	663,049	63,591	726,640	(55,566)	671,074			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			383,944	383,944		383,944		383,944			42
43	Other (specify):* Edu/Day Training	1,162,046	29,228	315,884	1,507,158		1,507,158		1,507,158			43
44	TOTAL Special Cost Centers	1,162,046	29,228	699,828	1,891,102		1,891,102		1,891,102			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,228,308	578,089	3,746,911	8,553,308		8,553,308	(200,745)	8,352,563			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(27,731)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,200)	27		24
25	Fund Raising, Advertising and Promotional	(36,383)	20,21,22		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(115,135)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (199,449)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(1,296)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,296)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (200,745)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Max Redmond - Employee Benefits	\$ (4,824)	22	1
2	Max Redmond - Wages	(27,851)	21	2
3	Public Relations	(3,708)	20	3
4	School Lunch Program	(84,892)	1	4
5	Goodwill	(27,835)	36	5
6	Non-Allowable Travel	(1,554)	24	6
7	Non-Allowable Seminar	(659)	24	7
8	Non-Allowable Dues	(195)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(151,518)		49

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Summary A

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(84,892)	0	0	0	0	0	0	0	0	0	0	(84,892)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(84,892)	0	0	0	0	0	0	0	0	0	0	(84,892)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(1,296)	0	0	0	0	0	0	0	0	0	(1,296)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,903)	0	0	0	0	0	0	0	0	0	0	(3,903)	20
21	Clerical & General Office Expenses	(27,851)	0	0	0	0	0	0	0	0	0	0	(27,851)	21
22	Employee Benefits & Payroll Taxes	(4,824)	0	0	0	0	0	0	0	0	0	0	(4,824)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,213)	0	0	0	0	0	0	0	0	0	0	(2,213)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(20,200)	0	0	0	0	0	0	0	0	0	0	(20,200)	27
28	TOTAL General Administration	(58,991)	(1,296)	0	0	0	0	0	0	0	0	0	(60,287)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(143,883)	(1,296)	0	0	0	0	0	0	0	0	0	(145,179)	29

Summary B

6/30/04

6/30/04

[illegible]

Facility Name & ID Number Swann Special Care Center

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Exceptional Care & Training Center	Sterling			
		Walter Lawson Children's Home	Loves Park			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland Bean-Blossom HCC	Ellettsville, Indiana			
		Hanover Nursing Center	Hanover, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Corporate Expense	\$ 188,953	Hoosier Care, Inc.	100.00%	\$ 187,657	\$ (1,296)	1
2	V								2
3	V				Note: See schedule VIII of allocation of cost per column 7.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 188,953			\$ 187,657	\$ * (1,296)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bruce Hutson, M.D.	Director	Board Meetings	0.00	7,441			Director Fees	\$ 2,076	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	7,441			Director Fees	2,076	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	7,441			Director Fees	2,076	18.8	3
4	John Foos	Director	Board Meetings	0.00	7,440			Director Fees	2,076	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	7,440			Director Fees	2,076	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,380		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Hoosier Care, Inc.

Street Address

535 West Second, Suite 105

City / State / Zip Code

Lexington, KY 40508

Phone Number

(859) 255-0075

Fax Number

(859) 281-5150

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10 Nursing / Medical Records	Revenue	40,575,961	8	\$ 255	\$ 0	8,851,433	\$ 56	1
2	18 Director's Fees	Revenue	40,575,961	8	47,583	0	8,851,433	10,380	2
3	19 Professional Fees	Revenue	40,575,961	8	267,033	0	8,851,433	58,252	3
4	20 Fees, Subscription & Promotion	Revenue	40,575,961	8	969	0	8,851,433	211	4
5	21 Clerical & General Office Exp.	Revenue	40,575,961	8	189,427	0	8,851,433	41,323	5
6	22 Emp. Benefits & Payroll Tax	Revenue	40,575,961	8	30,076	0	8,851,433	6,561	6
7	24 Travel & Seminar	Revenue	40,575,961	8	11,189	0	8,851,433	2,441	7
8	30 Depreciation	Revenue	40,575,961	8	136	0	8,851,433	30	8
9	32 Interest Expense	Revenue	40,575,961	8	313,568	0	8,851,433	68,403	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 860,236	\$		\$ 187,657	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Ill. Health Financing Authority		X	Purchase of Facility	Varies	7/8/99	\$ 5,710,000	\$ 5,490,000	6/1/2034	7.1250	\$ 393,538	1	
2	Ill. Health Financing Authority		X	Purchase of Facility	Varies	7/8/99	260,000	235,000	6/1/2019	10.5000	25,156	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Home Office Allocation										68,403	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 5,970,000	\$ 5,725,000			\$ 487,097	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 5,970,000	\$ 5,725,000			\$ 487,097	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Swann Special Care Center**# **0035485** Report Period Beginning: **7/1/03** Ending: **6/30/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2003 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1999	None	8	
	2000		9	
	2001		10	
	2002		11	
	2003		12	
Note: The facility became exempt from property taxes starting 1/1/96.				

		FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Swann Special Care Center COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0035485

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF/PED	89,603	1989	\$ 538,000	1
2					2
3	TOTALS	89,603		\$ 538,000	3

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/03

Ending:

6/30/04

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	87		1989	1975	\$ 2,592,000	\$ 56,275	10-40	\$ 56,275		\$ 1,180,435	4
5	9			1993	319,955	10,665	30	10,665		139,856	5
6	8			1996	N/A		N/A				6
7	8			2000	157,933	5,264	30	5,264		19,742	7
8											8
	Improvement Type**										
9	Paint & Panels			1989	1,308		3			1,308	9
10	Blinds			1990	384		3			384	10
11	Fire Doors			1990	2,751		10			2,751	11
12	Storm Windows			1991	4,224		10			4,224	12
13	Fire Doors			1991	3,675		10			3,675	13
14	Compressor			1991	1,035		10			1,035	14
15	Carpeting			1991	220		10			220	15
16	Sprinkler & Fire Alarm			1991	695		10			695	16
17	Sprinkler			1992	3,162		10			3,162	17
18	Damper			1992	674		10			674	18
19	Fire Alarm System			1992	1,945		10			1,945	19
20	Water Heater			1992	1,998		7			1,998	20
21	Roofing			1992	3,900		10			3,900	21
22	Voltage Relay			1993	1,875		10			1,875	22
23	Sprinkler System			1993	14,460		10			14,460	23
24	Wall Covering			1993	3,190		10			3,190	24
25	Wall Papering			1993	3,000		10			3,000	25
26	Blinds with Valance			1993	2,395		10			2,395	26
27	Carpet and Rubber Base			1993	2,848		10			2,848	27
28	Replace Siding			1993	575	8	10	8		575	28
29	Remodeling in Team Rooms			1993	9,405	231	10	231		9,405	29
30	Plexiglas for Doors & Walls			1993	714	21	10	21		714	30
31	Resurface Parking Lot			1993	19,115	641	10	641		19,115	31
32	Shed			1993	5,990	50	10	50		5,990	32
33	Stain New Shed			1993	1,248	19	10	19		1,248	33
34	Fire Doors, Closets, Tile			1993	5,225	178	10	178		5,225	34
35	Architectural Renovation			1993	855	39	10	39		855	35
36	Install Alarm & Nurse Call			1994	688	45	10	45		688	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Heat Pump	1994	\$ 2,017	\$ 166	10	\$ 166	\$	\$ 2,017		37
38	Paving for New Sign	1994	680	62	10	62		680		38
39	Labor for Laying Brick - Sign	1994	1,000	92	10	92		1,000		39
40	Sign for Dedication	1994	325	32	10	32		324		40
41	Sign and Granite Pieces	1994	1,300	119	10	119		1,300		41
42	Material for Leasehold Improvements	1995	7,858		3			7,858		42
43	Hoods, Fans, Ansul System	1995	2,500	250	10	250		2,333		43
44	Work for Exhaust Fan & Hood	1995	3,995	399	10	399		3,691		44
45	Day Room Addition	1995	3,337	334	10	334		3,034		45
46	Replace Water Heater	1995	3,750	375	10	375		3,406		46
47	Day Room Additional Supplies	1995	1,926	193	10	193		1,753		47
48	Walk-in-Cooler	1995	3,334	333	10	333		2,914		48
49	Nurse Call System	1996	1,198	120	10	120		1,000		49
50	Shed	1996	2,034	203	10	203		1,675		50
51	Air Conditioner Compressor	1996	1,208	121	10	121		978		51
52	Supplies for Leasehold Improvements	1996	3,091		3			3,091		52
53	Building Addition - Materials & Labor - 1,500 Square Feet Multi-Purpose									53
54	Activity Room & Bathroom Addition plus renovation to the Dental Office	1996	180,928	9,046	20	9,046		74,630		54
56	Construct Screens, Wheelchairs	1996	1,420		3			1,420		56
57	Construct Shelving, Beds, Screen	1996	2,964		3			2,964		57
58	Install Nurse Call System	1996	1,530	153	10	153		1,224		58
59	Tile Flooring & Adhesive	1996	1,227	123	10	123		963		59
60	Linoleum Flooring	1996	686	69	10	69		529		60
61	Install New Drain Pipes	1996	2,190	219	10	219		1,679		61
62	Remove Concrete to Replace Drain Pipes	1996	575	58	10	58		444		62
63	Install Exit Door Hardware	1997	874	87	10	87		645		63
64	Day Training Improvement	1997	4,078		4			4,078		64
65	Install New Disposal	1997	1,069	107	10	107		722		65
66	Replace Four-Door Glass	1998	520	52	10	52		329		66
67	Remove / Replace Underground Fuel Tank	1998	9,223	461	20	461		2,612		67
68	Remodel Project 2410 Springfield	1998	33,764		4			33,764		68
69	Partition Wall Kitchen / Dinning Area	1998	595	74	8	74		413		69
70	TOTAL (lines 4 thru 69)		\$ 3,448,638	\$ 86,684		\$ 86,684	\$	\$ 1,601,057		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,448,638	\$ 86,684		\$ 86,684		\$ 1,601,057	1
2	Replace Two Roof-Top HVAC Units-Wings I&II	1998	17,650	1,765	10	1,765		9,855	2
3	Replace Vent Damper Assembly - Hot Water Heater	1998	740	74	10	74		413	3
4	Convert Two Classrooms into Resident Rooms	1998	15,258	1,526	10	1,526		8,520	4
5	Security Door and Hardware - Converted Rooms	1999	520	52	10	52		282	5
6	Remove / Replace Hot Water Heater - Resident Area	1999	3,000	300	10	300		1,550	6
7	Replace Combustion Motor/Fan on Heater - West Wing	1999	1,155	116	10	116		609	7
8	Electrical Service Move Switches	1999	141	18	8	18		97	8
9	Installation of Water Heaters	1999	595	60	10	60		310	9
10	Resurface Parking Lot	1999	2,350	157	15	157		772	10
11	14 Almond FRP Panel Dividers	1999	513	103	5	103		506	11
12	Install Alarm System	2000	2,000	400	5	400		1,633	12
13	Install Alarm System	2000	2,730	546	5	546		2,230	13
14	Replaced Compressor on Freezer	1999	635	63	10	63		305	14
15	Replace Grout, Base, and Tile for Bathroom Floors	1999	594	40	15	40		193	15
16	Replaced Bracket / Filter Head, Brushes, Relay on Generator	1999	2,782	278	10	278		1,321	16
17	Storage Barn	1999	120	5	25	5		24	17
18	Storage Barn	1999	1,045	42	25	42		199	18
19	Replaced Wall Heat Pump Unit	1999	1,525	153	10	153		726	19
20	New Mixing / Tempering Valve for Hot Water	2000	629	63	10	63		283	20
21	Replace Timer / Starter on Emergency Generator	2000	2,153	215	10	215		968	21
22	Install Interior Retrofit Energy Efficient Lighting	2000	15,090	755	20	755		3,272	22
23	Intstall Clinical Sink	2000	3,030	606	5	606		2,424	23
24	Stoneybrook Remodeling PR	2000	138,235	27,647	5	27,647		103,676	24
25	Install Doors at Kenwood	2000	4,028	269	15	269		1,076	25
26	Replace Gate Valve	2000	6,005	400	15	400		1,534	26
27	Replace Ceiling Tile	2000	674	67	10	67		257	27
28	Materials to Tile Bathroom	2001	784	78	10	78		280	28
29	Install Booster Pump	2001	1,995	133	15	133		465	29
30	Install Tile in Bathroom	2001	825	55	15	55		192	30
31	New Floor Drains In Shower	2001	3,180	212	15	212		742	31
32	Replace Reversing Valve	2001	599	60	10	60		190	32
33	Replacement Parts for Roof	2001	662	66	10	66		209	33
34	TOTAL (lines 1 thru 33)		\$ 3,679,880	\$ 123,008		\$ 123,008		\$ 1,746,170	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,679,880	\$ 123,008		\$ 123,008	\$	\$ 1,746,170	1
2	Tile for Bathroom	2001	1,854	185	10	185		570	2
3	Stoneybrook Awning	2001	15,560	3,112	5	3,112		10,892	3
4	Stoneybrook Telephone System	2001	1,668	334	5	334		1,169	4
5	Comp. Ed. Room at Stoneybrook	2001	2,431	486	5	486		1,701	5
6	Stoneybrook Shelves - Inst	2001	516	103	5	103		352	6
7	Remodeling	2001	8,351	1,670	5	1,670		4,732	7
8	Sprinkler System Renovation	2001	760	51	15	51		153	8
9	Install Shower Drains	2001	10,500	525	20	525		1,575	9
10	Tile to Repalce Tubs	2001	1,278	85	15	85		255	10
11	Rewired and Replaced Compressor / HVAC	2001	1,404	140	10	140		409	11
12	Replace Laundry Panel	2001	1,179	79	15	79		217	12
13	Valve-Water Heater	2001	876	88	10	88		242	13
14	Internet Set-up Wiring Cable	2002	6,141	409	15	409		989	14
15	Thermostats with Locking Guards	2002	1,371	91	15	91		197	15
16	Classroom Remodel	2002	5,978	598	10	598		1,395	16
17	Replace Fencing Around Dumpster Area	2002	674	67	10	67		145	17
18	Replace Doors	2002	3,000	600	5	600		1,500	18
19	Security System	2002	3,165	633	5	633		1,530	19
20	Remodeling	2002	8,351	1,670	5	1,670		3,897	20
21	Electrical Labor-Remodeling	2002	1,425	285	5	285		665	21
22	Install Two Sinks	2002	3,561	712	5	712		1,543	22
23	Revise Sprinkler System	2002	501	100	5	100		225	23
24	Re-seal & Re-stripe Parking Lot	2002	2,810	281	10	281		562	24
25	Install New Phone System	2002	2,735	547	5	547		957	25
26	Install New Phone System / Day Training	2002	2,488	498	5	498		871	26
27	Carpet & Installation	2002	2,954	295	10	295		590	27
28	New Mother Board / Alarm System	2002	1,490	149	10	149		286	28
29	Install A/C Rooftop Unit	2002	8,237	549	15	549		1,052	29
30	New 2nd Rooftop Compressor	2002	762	51	15	51		93	30
31	Height Adjustment Supine Tub	2002	8,469	847	10	847		1,341	31
32	Relief Valves / Booster Heater	2003	555	56	10	56		84	32
33	Central Heat / Air Rooftop	2003	5,180	345	15	345		518	33
34	TOTAL (lines 1 thru 33)		\$ 3,796,104	\$ 138,649		\$ 138,649	\$	\$ 1,786,877	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,796,104	\$ 138,649		\$ 138,649		\$ 1,786,877	1
2	New Tile and Base Floor	2003	847	85	10	85		127	2
3	New Hydrotherapy Tub	2003	1,900	190	10	190		285	3
4	Electric Water Heater	2003	5,600	560	10	560		747	4
5	Exhaust Fan	2003	525	53	10	53		57	5
6	Remodeling	2003	8,351	1,670	5	1,670		2,505	6
7	Install Dry Pendent Sprinkler in Freezer	2003	675	62	10	62		62	7
8	Rooftop Unit Installed / Heat Air Wing 3	2003	10,910	667	15	667		667	8
9	60 X 94 Lami Glass	2003	179,834	1,998	30	1,998		1,998	9
10	New Wing	2004	839	80	7	80		80	10
11	Installing Draining System in Courtyard	2004	9,268	552	7	552		552	11
12	5th Annual Payment on Remodeling	2004	8,351	835	5	835		835	12
13	Drainage System for Courtyard	2004	501	12	7	12		12	13
14	Lift Pump for Drinking Fountain	2004	1,040	17	5	17		17	14
15	Rounding		2	(9)		(9)		(8)	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,024,747	\$ 145,421		\$ 145,421		\$ 1,794,813	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 157,077	\$ 25,953	\$ 25,953			\$ 97,168	71
72	Current Year Purchases	28,542	2,115	2,115			2,115	72
73	Fully Depreciated Assets	481,102	1,083	1,083			481,102	73
74	Corporate Allocation		30	30				74
75	TOTALS	\$ 666,721	\$ 29,181	\$ 29,181	\$		\$ 580,385	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1985 GMC Bus	1993	\$ 16,250	\$	\$			\$ 16,250	76
77	Patient Transportation	1985 GMC Bus	N/A	4,041					4,041	77
78	Patient Transportation	1989 Ford Mini Bus	1998	3,000	150	150			3,000	78
79	See Attached			45,214	9,754	9,754			31,910	79
80	TOTALS			\$ 68,505	\$ 9,904	\$ 9,904	\$		\$ 55,201	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,297,973	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 184,506	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 184,506	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,430,399	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Classroom Conversion to	\$ 9,200	92
93	Patient Rooms		93
94			94
95		\$ 9,200	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 16,654

Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$

13. /2006 \$

14. /2007 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 12,174	\$	1
2	Cash-Patient Deposits	92,340		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (40,600)	1,005,988		3
4	Supply Inventory (priced at Cost)	44,791		4
5	Short-Term Investments			5
6	Prepaid Insurance	8,827		6
7	Other Prepaid Expenses	5,795		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to / from Corporate	(4,498,420)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (3,328,505)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	538,000		13
14	Buildings, at Historical Cost	4,024,747		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	735,226		16
17	Accumulated Depreciation (book methods)	(2,430,399)		17
18	Deferred Charges	316,429		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,277		21
22	Other Long-Term Assets (specify):	540,571		22
23	Other(specify): Goodwill	698,204		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,425,055	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,096,550	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (58,037)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	92,340		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	199,445		30
31	Accrued Taxes Payable (excluding real estate taxes)	36,100		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	34,653		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 304,501	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,725,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,725,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,029,501	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (4,932,951)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,096,550	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,258,810)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,258,810)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	325,857	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	2	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 325,859	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,932,951)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,736,698	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,736,698	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education	908,559	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	38,120	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 946,679	23
	D. Non-Operating Revenue		
24	Contributions	36,338	24
25	Interest and Other Investment Income***	27,731	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 64,069	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>DMH Day Training</u>	1,046,827	28
28a	<u>School Lunch Program</u>	84,892	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,131,719	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,879,165	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	956,459	31
32	Health Care	3,217,781	32
33	General Administration	1,824,917	33
	B. Capital Expense		
34	Ownership	663,049	34
	C. Ancillary Expense		
35	Special Cost Centers	1,507,158	35
36	Provider Participation Fee	383,944	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,553,308	40
41	Income before Income Taxes (line 30 minus line 40)**	325,857	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 325,857	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Swann Special Care Center# 0035485Report Period Beginning: 7/1/03Ending: 6/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,962	2,080	\$ 52,073	\$ 25.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,594	21,005	442,317	21.06	3
4	Licensed Practical Nurses	13,632	14,558	257,930	17.72	4
5	Nurse Aides & Orderlies	125,934	135,853	1,577,313	11.61	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,326	1,462	26,676	18.25	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,804	2,088	31,524	15.10	9
10	Activity Assistants	20,699	22,017	182,978	8.31	10
11	Social Service Workers	46	46	2,092	45.48	11
12	Dietician					12
13	Food Service Supervisor	1,946	2,096	38,033	18.15	13
14	Head Cook	8,316	9,007	112,924	12.54	14
15	Cook Helpers/Assistants	2,319	2,513	28,419	11.31	15
16	Dishwashers	2,198	2,368	29,956	12.65	16
17	Maintenance Workers	4,101	4,357	49,852	11.44	17
18	Housekeepers					18
19	Laundry	2,405	2,629	38,018	14.46	19
20	Administrator	1,944	2,080	59,815	28.76	20
21	Assistant Administrator					21
22	Other Administrative	1,504	1,544	16,686	10.81	22
23	Office Manager					23
24	Clerical	5,810	6,090	119,656	19.65	24
25	Vocational Instruction					25
26	Academic Instruction	33,256	37,036	497,405	13.43	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	4,343	4,628	60,474	13.07	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Day Training</u>	47,903	51,184	604,167	11.80	33
34	TOTAL (lines 1 - 33)	301,042	324,641	\$ 4,228,308 *	\$ 13.02	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	365	\$ 12,569	1.3	35
36	Medical Director	N/A	36,000	9.3	36
37	Medical Records Consultant	N/A	75	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	675	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant	1,037	55,592	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,046	58,485	10a.3	43
44	Activity Consultant	10	400	11.3	44
45	Social Service Consultant	47	2,363	12.3	45
46	Other(specify) <u>Dental Fees</u>	N/A	3,593	10.3	46
47	<u>Resident Transport</u>	N/A	740	14.3	47
48	<u>See Attached</u>	9,929	233,495		48
49	TOTAL (lines 35 - 48)	12,434	\$ 403,987		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,159	\$ 136,967	10.3	50
51	Licensed Practical Nurses	3,552	131,008	10.3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	6,711	\$ 267,975		53

Facility Name & ID Number Swann Special Care Center# 0035485Report Period Beginning: 7/1/03Ending: 6/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%			Description			Description			
Mary Lou Bedient	Administrator	0	\$	59,815	Workers' Compensation Insurance	\$	152,063	IDPH License Fee	\$		
					Unemployment Compensation Insurance		24,245	Advertising: Employee Recruitment		451	
					FICA Taxes		317,500	Health Care Worker Background Check			
					Employee Health Insurance		214,053	(Indicate # of checks performed <u>107</u>)		1,286	
					Employee Meals			Illinois Health Care Assoc.		6,148	
					Illinois Municipal Retirement Fund (IMRF)*			Council for Exceptional Children		109	
					Employee Benefits - Other		19,842	Public Relations		6,152	
					Corporate Allocation		6,561	Chamber of Commerce		195	
								Corporate Allocation		211	
								Other Fees (See Attached)		12,701	
								Less: Public Relations Expense		(3,708)	
								Non-allowable advertising		(195)	
								Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$	59,815				TOTAL (agree to Sch. V,	\$	23,350	
(List each licensed administrator separately.)								line 20, col. 8)			
B. Administrative - Other					TOTAL (agree to Schedule V,			\$	734,264		
								line 22, col.8)			
Description				Amount	E. Schedule of Non-Cash Compensation Paid						
Corporate Expense			\$	188,953	to Owners or Employees						
					Description	Line #	Amount	G. Schedule of Travel and Seminar**			
					None			Description		Amount	
								Out-of-State Travel	\$	1,554	
								Non-Allowable Out-of-State Travel		(1,554)	
								In-State Travel		4,851	
								Seminar Expense		6,722	
								Non-Allowable Seminar		(659)	
								Corporate Allocation		2,441	
								Entertainment Expense	()	
								(agree to Sch. V,			
TOTAL (agree to Schedule V, line 17, col. 3)			\$	188,953	TOTAL			\$			
(Attach a copy of any management service agreement)											
C. Professional Services								TOTAL (agree to Sch. V,			
Vendor/Payee	Type		Amount					line 24, col. 8)	\$	13,355	
Medical Rehabilitation		\$									
Centers, Inc.	Management Fees		511,200								
Thomas Healthcare Consulting	Accounting Fees		3,750								
Hensley Law Office	Legal Fees		549								
Duane, Morris & Heckscher	Legal Fees		25,000								
Secrest, Wardle & Lynch	Legal Fees		132								
Nally, Haasis & Jordan	Legal Fees		453								
Erwin, Martinkus & Fein	Legal Fees		26								
TOTAL (agree to Schedule V, line 19, column 3)			\$	541,110							
(If total legal fees exceed \$2500 attach copy of invoices.)											

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Swann Special Care Center

STATE OF ILLINOIS

0035485

Report Period Beginning:

7/1/03

Ending:

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6/30/04

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Schedule XIX, Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,791 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 383,944
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 84,892
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 34,437
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Resnick, Fedder & Silverman The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.